



RI Health Plans' Performance Report (2008)



David R. Gifford, MD, MPH
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Donald L. Carcieri
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Health Insurance Commissioner



November, 2009

To all Rhode Islanders:

We are pleased to present the 11th annual publication of the *RI Health Plans' Performance Report*. This Report, based on 2008 commercial health plan data, provides information on 31 separate measures covering 8 dimensions of performance (i.e., enrollment, costs, utilization, prevention, screening, treatment, access, and satisfaction). Health plan performance is trended over time, compared to regional averages, and benchmarked to the best 10% of health plans nationally.

Performance benchmarking serves to focus healthcare improvement efforts, and holds health plans accountable for the way their services are provided. This information is also used by programs to gauge progress in improving the health status of Rhode Islanders, and may guide policy-makers in their efforts to create a healthcare delivery system promoting prevention and primary care.

Quality measures for Blue Cross and Blue Shield of RI and United Healthcare of NE compared fairly well to their New England peers, in general. In addition, these two plans have historically been less expensive than their regional counterparts, but their favorable pricing weakened in 2008.

Several measures in this report illustrate opportunities for plans to improve healthcare delivery in the state. For example, RI's 2008 commercial *chlamydia screening* rates were about 45 percent, and *antidepressant medication treatment* rates were under 40 percent. These and other measures demonstrate the need for targeted primary care for early detection and disease management.

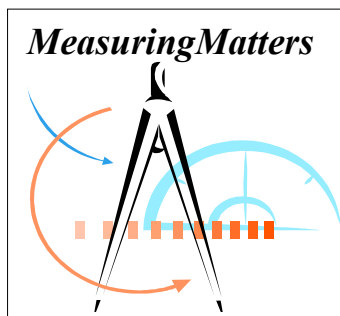
The Department of Health and Office of the Health Insurance Commissioner appreciate RI's health plans' commitment to quality improvement, and their support in shaping RI's healthcare system to promote cost-effective, high quality services.

Sincerely,

David R. Gifford, MD, MPH
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I: EXECUTIVE SUMMARY

RI's two domestic commercial health insurers (Blue Cross and United) provided fair value to their customers in 2008. Their average costs approached, but remained below those in New England (Chart 1), and their quality measures were generally equivalent to their regional peers (Table 1).

The 1996 Health Care Accessibility and Quality Assurance Act instituted the submission and analysis of health plan data in the state. This 2008 report fulfills the statutory reporting requirements of RIGL 23-17.13-3. It is the 11th edition to present health plan performance information, trended over time, and compared to regional averages, and national benchmarks.

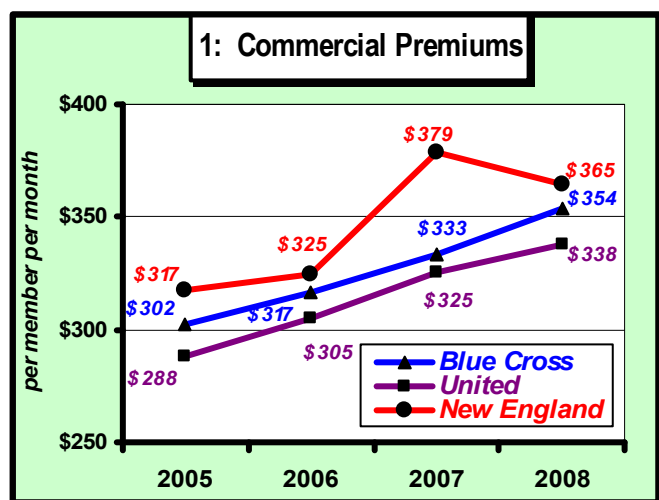
With a small state population, few commercial underwriters, and the market dominance of Blue Cross & Blue Shield of RI (Blue Cross), most Rhode Islanders have limited choice of carrier. The lack of selective contracting also means that most plans deliver services through the same network of caregivers (i.e., the majority of physicians, hospitals and other providers participate in most, if not all plans).

Therefore, the value in publishing this information is primarily in promoting accountability of the industry. Purchasers deserve to know how well the plans are performing and policymakers need empirical evidence to set effective guidelines. Healthcare programs also need tools to benchmark progress in improving health status. An added benefit is that plan performance may improve simply by making the results public.

Some 296,000 Rhode Islanders were commercially insured in 2008, and this report analyzes the two largest health plans, which together covered over 76% of this population (i.e., Blue Cross and UnitedHealthcare of New England (United)). In all, eight separate dimensions of performance are evaluated, ranging from enrollment, costs, utilization and prevention, to screening, treatment, access, and satisfaction. A separate, companion publication, *The Health of RI's Health Insurers (2008)*, provides a financial analysis of the state's domiciled insurers.

RI's health insurance market is concentrated in two carriers. Blue Cross had a share of 64.5% and United controlled 11.8% of the commercial market. The remainder (23.6%), consisted of a host of smaller plans, all incorporated out-of-state.

Cost and quality are the two determinants of value. For Rhode Islanders to receive value from their investment in health insurance, that coverage should be equivalent or less expensive and deliver the same or better quality services than elsewhere. Chart 1 graphs the average 2005-2008 monthly premiums paid for commercial coverage.



Rhode Islanders have historically paid less than their regional counterparts for commercial health insurance. In 2005, Blue Cross was 5% less expensive than the New England comparable, while United was 9% less expensive. In 2008, those differences were -3% and -7%, respectively.¹

RI's two commercial health plans performed fairly well when their quality measures were compared to their New England peers in 2008 (Table 1). For Blue Cross, nine of its 19 quality measures were equivalent to the regional averages, four measures were better, and the remaining six were worse than these comparables. For United, 11 of its 19 quality measures were equivalent to the regional averages, five measures were better, and the remaining three were worse.

¹ Care should be taken in comparing premiums as covered benefits and risk characteristics of members may differ between plans

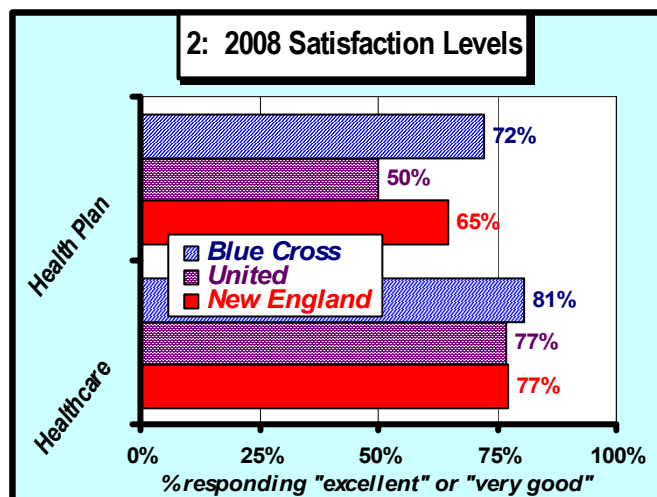
1: 2008 Health Plan Quality Performance

Dimension/Measure	N.E. Aver- ages	Relative to N.E. Averages ¹	
		Blue Cross	United
PREVENTION			
1 Adult Flu Vaccinations	50.3%	11%	=
2 Smokers Advised to Quit	82.4%	=	=
3 Smokers Advised on Meds.	62.8%	-7%	6%
4 Smokers Advised on Methods	59.2%	-7%	=
SCREENING			
5 Breast Cancer Screening	76.1%	=	=
6 Cervical Cancer Screening	82.8%	=	=
7 Chlamydia Screening	49.0%	-8%	-8%
8 Diabetic Eye Exams	63.5%	-6%	=
9 Diabetic HbA1c Testing	89.6%	=	=
TREATMENT			
10 Hypertension Controlled	56.7%	14%	14%
11 Beta Blocker Treatment	79.5%	-11%	-7%
12 Asthma Medication Treatment	92.3%	=	=
13 Antidepressant Medication Tx.	50.1%	-21%	-23%
ACCESS			
14 Follow-up for Mental Illness	82.1%	=	12%
15 Prenatal Visits	84.4%	10%	8%
16 Postpartum Visits	74.7%	12%	=
17 Well Child Visits (1 st 15 mos.)	84.5%	=	7%
18 Well Child Visits (3 rd -6 th yrs.)	83.4%	=	=
19 Adolescent Well-Care Visits	59.4%	=	=

¹ '=' indicates that the relative difference from the N.E. average was less than +/-5%

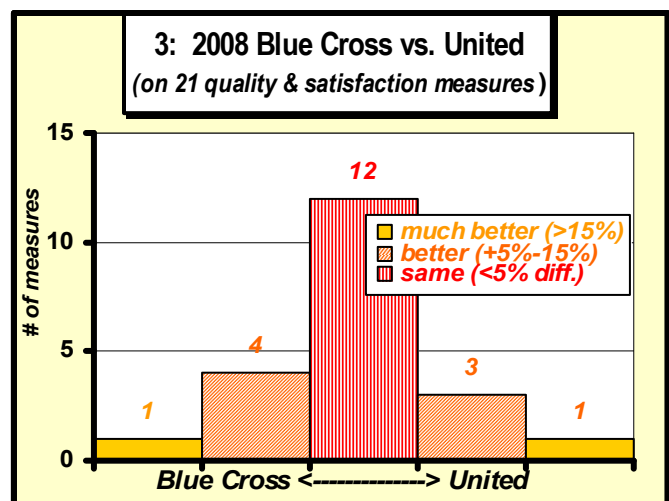
Irrespective of the acceptable relative performance of the plans in general, the weak absolute values on some clinical measures is concerning. For example, the local *Chlamydia Screening*, and *Antidepressant Medication Treatment* rates under 50%, highlight the need for improvement.

Chart 2 graphs plan members' satisfaction with their health plans and their healthcare services.



Blue Cross' 2008 health plan satisfaction rate (72%) was 12% higher than the regional rate (65%), while United's rate (50%) was 23% below that comparable. The healthcare satisfaction rates of Blue Cross and United were not appreciably different from the New England average (81%, and 77%, respectively, vs. 77%). In keeping with the experience in prior years, more members expressed satisfaction with their healthcare services than with their health plans, regardless of location.

Chart 3 provides a Blue Cross/United comparison on the 19 quality and two satisfaction measures.



The overall satisfaction and quality performances of Blue Cross and United were not appreciably different in 2008. Blue Cross outperformed United on five measures, 12 measures were essentially similar between the two plans, and United outperformed Blue Cross on four measures. On a cost basis, however, United was 4% less expensive than Blue Cross in 2008 (\$338 vs. \$354 per member per month)

II: INTRODUCTION

Increasingly, the public, purchasers, providers, and policy-makers are seeking meaningful information about commercial health insurers. This report provides the most comprehensive public source of data on plans certified to operate in Rhode Island.²

Consumers and purchasers may use this information to make informed choices among competing plans or to understand their chosen plan better. The plans themselves have comparative statistics to identify and focus improvement efforts, and policymakers may use this information to support their decision-making. Lastly, healthcare programs may use these data to benchmark their own performances.

Not all health insurers are identical. They differ in how they keep members well and how they care for them when they are ill, even though their provider networks may be similar. They also differ in how they provide access to and deliver services. Most Rhode Islanders receive their health coverage through the two commercial plans in this report, so learning about how they perform is essential to determining if value is received from the premium dollars expended.

Consequently, and in response to this need for information, the Rhode Island General Assembly passed the Health Care Accessibility and Quality Assurance Act (RIGL 23-17.13) in 1996. One stipulation of this law was a requirement that health plans submit performance data to the RI Department of Health (RI-DOH). This report ful-

fills the statutory reporting requirements of the Act.

To consumers, the quality, and access to care provided by a plan may affect their health. To employers, these same issues may influence worker absenteeism, productivity and the company's personnel costs.

The *RI Health Plans' Performance Report (2008)* is the 11th annual publication of this information. The report is divided into sections containing similar dimensions of performance. Section III examines enrollment and market share. Section IV provides cost information, and section V compares utilization statistics. Section VI looks at prevention measures, and section VII gives screening information. Section VIII presents treatment statistics and section IX shows access measures. Lastly, section X provides the results of member satisfaction surveys. When relevant, the regional (New England) averages and national 90th percentile values are provided to assess the plans' performances relative to these comparables and benchmarks.

This report examines commercial health plans only, it does not include Medicaid (Rite Care) or Medicare HMO plans. Information on the financial performance of RI's health insurers is presented in a companion publication, *The Health of RI's Health Insurers (2008)*.

The following guidelines should help improve the utility of this report.

- **No one measure in and of itself can accurately reflect health plan performance.** Therefore, the statistics should be viewed in combination and not in isolation.
- **Readers should focus on large differences between health plans** that are less likely to be caused by random chance. When comparing statewide performance to the regional values or national benchmarks, differences less than +/-5% usually do not signify any meaningful variations.³

² Blue Cross and Blue Shield of Massachusetts is included in this group and its performance data are included in Appendix C (but not analyzed in the body of the report), and United Healthcare Insurance Company (UHIC), a Connecticut domiciled insurer and 'sister' corporation to UnitedHealthcare of NE (United), is also included in this group but its data were not included because it was granted a waiver from reporting separate HEDIS and CAHPS measures from the RI-DOH's Office of Managed Care Regulation (i.e., for the HEDIS and CAHPS measures, its data are identical to that for United). UHIC had the following RI members: 11,652, 22,738, 20,742, and 23,505 for 2005-2008, respectively. All other health plans in this group had fewer than 20,000 fully-insured RI members, and were exempt from filing any data (to reduce their reporting burdens). In addition, this report excludes members enrolled in self-insured plans administered by these and other carriers that are exempt from state regulation (i.e., through ERISA).

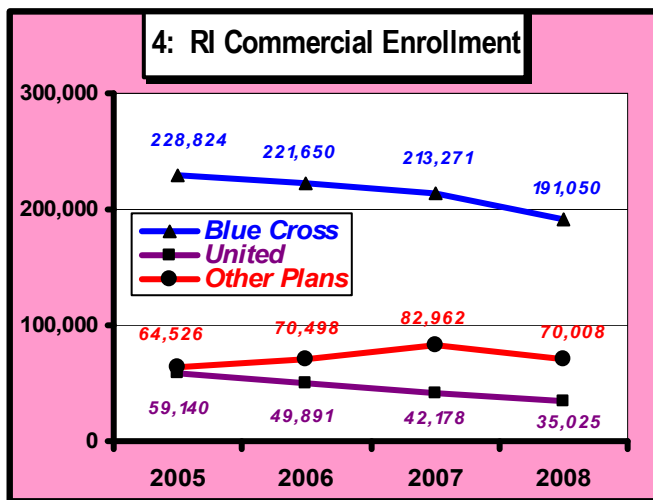
³ Confidence intervals were not calculated for Blue Cross' clinical, access, and satisfaction measures because they are a composite of the HEDIS and CAHPS values for its commercial PPO and HMO products, therefore, differences in values for these measures that are less than +/-5% are considered to be too small to be significant.

- **Readers should recognize there may be reasons why results vary other than differences in quality or administration.** Every plan enrolls a distinct set of members with unique demographic characteristics that could affect performance (e.g., age, health status, race/ethnicity, socioeconomic status). In addition, differences in covered benefits may also influence outcomes.
- **This report examines all types of commercial health plans (i.e., HMO, POS and PPO).** HMOs are legally defined and, generally, use restricted networks to deliver care through the member's primary care provider. In addition, they may employ a variety of managed care techniques to coordinate care and control costs (e.g., 'gatekeepers', second opinions, formularies, restricted networks, etc.). As other plans employ these same techniques, and as the popularity of traditionally-defined HMOs wanes, this distinction becomes less apparent and important.
- **This report excludes plans with fewer than 20,000 RI members.** These insurers are fairly minor competitors in the RI marketplace at this time and, to reduce their reporting burden, they are exempt from filing. Also, given their smaller market shares, they do not influence providers' practices to any significant extent.
- **Comparable data** (i.e., the New England averages and the national 90th percentile values) are from other commercial health plans included in Quality Compass (National Committee for Quality Assurance). In the text, reference are made to U.S. or national benchmarks. The benchmarks are the cutoff values for the best-performing decile (10%) of health plans nationally (Appendix E). Therefore, these benchmarks are the 90th percentile national values (e.g., the 2008 *Adult Flu Vaccinations* benchmark of 58.1% means that 90% of plans across the country had values below 58.1%, and 10% had values above 58.1%). For the one measure in which lower values are preferred (i.e., *ED Visits*), the benchmark is the 10th national percentile value.
- **The raw data** for Blue Cross –RI, United, and Blue Cross –MA are presented in Appendices A through C. The comparable New England averages, and the national benchmark values are presented in Appendices D and E, respectively.

III: ENROLLMENT

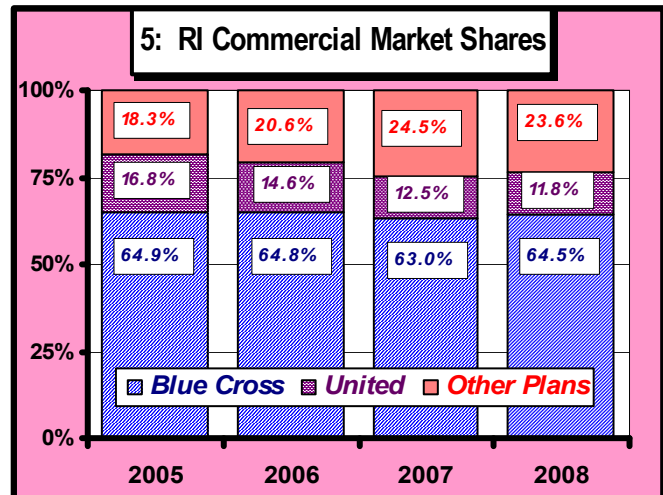
This section compares health plan membership information and market shares. Included is the fully-insured commercial book-of-business only. Excluded are the self-insured members for which the plans provide third party administrators' (TPA) or administrative services only (ASO) services.

A. RI Enrollment is the computed RI resident enrollment in a health plan for the full year (Chart 4). Increasing enrollment over time is important both in terms of achieving economies of scale and increasing market share.



Blue Cross remained the largest commercial carrier with 191,000 fully-insured RI members, and United had 35,000 RI members. Total RI commercial enrollment fell every year, from 352,000 in 2005 to 296,000 in 2008, reflecting the general decline in insurance coverage and the switch to self-insurance by some larger companies.

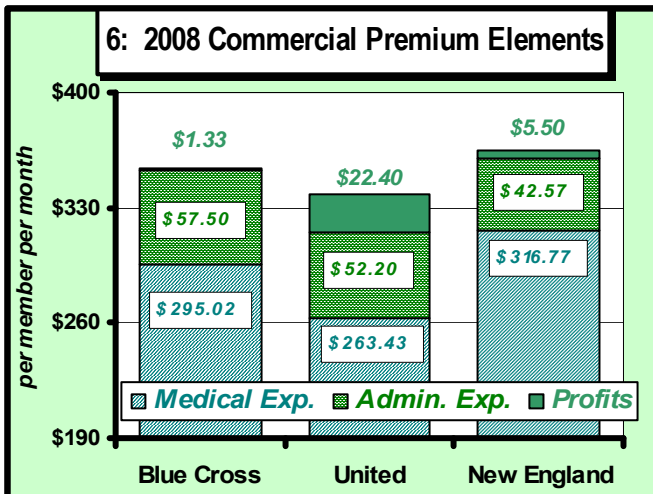
B. RI Market Shares calculates each plan's percentage of the total RI fully-insured enrollment (Chart 5). In many respects, market share is more important than simple enrollment (although the two are related). It is possible in a shrinking market such as RI, for a plan's enrollment to decline while its market share increases (e.g., Blue Cross in 2008). Market share, to a large extent, determines how aggressively a plan can negotiate its provider contracts, rates, and commissions.



Blue Cross' market shares were relatively stable since 2005, and it controlled 65% of the domestic commercial market in 2008. United's share has eroded over time, to 12% of the market in 2008.

IV: COSTS

This section compares health plan cost information. Chart 6 presents the average costs of commercial insurance coverage in 2008, as well as the amounts spent on healthcare services, administrative expenses, and the profits remaining (on a per member per month (PMPM) basis).



In 2008, Blue Cross' monthly premium (\$354) was 3% less than the New England rate (\$365), and United's premium (\$338) was 7% below that comparable.

Care should be exercised in comparing premiums. One plan may be less expensive than another, but that doesn't necessarily mean it is a better value. Different insurers may sell plans with different benefits, co-pays or deductibles. Therefore, the total healthcare cost for a member in a less expensive plan may actually be greater than a more expensive plan that has fewer co-pays, lower deductibles, or more covered services the member needs.

Medical expenses are the amounts plans spend on healthcare services for their members. Consumers generally favor higher medical expenses, because they indicate more of the premium dollars going into their healthcare (all else being equal). Lower medical expenses, however, do not necessarily imply that an insurer restricts access to services. Lower expenses could instead mean that a plan's members are less ill, that the plan includes a less expensive benefits package, that the plan is more effective at managing care

for its members, or that its reimbursement rates to providers are lower than its competitors.

In 2008, Blue Cross' monthly medical expenses (\$295) were 7% less than those in New England (\$317), and United's medical expenses (\$263) were 17% below that comparable.

Administrative expenses are those costs incurred from operating the health plan, and marketing its products. Many administrative expenses are fixed, so controlling them is essential to maximizing profits. Generally, consumers favor lower administrative expenses as a matter of course, expecting that these monies could instead go into direct medical services to members.

In 2008, Blue Cross' monthly administrative expenses (\$57.50) were 35% greater than those in New England (\$42.57), and United's administrative expenses (\$52.20) were 23% above that comparable.

Profits are the monthly net income amounts generated per member from underwriting the commercial book-of-business after all associated expenses have been paid. Profits are critical, even for non-profit insurers (e.g., Blue Cross), because they allow the organization to remain solvent (i.e., add to the surplus), to increase marketing, and to invest in new information systems.

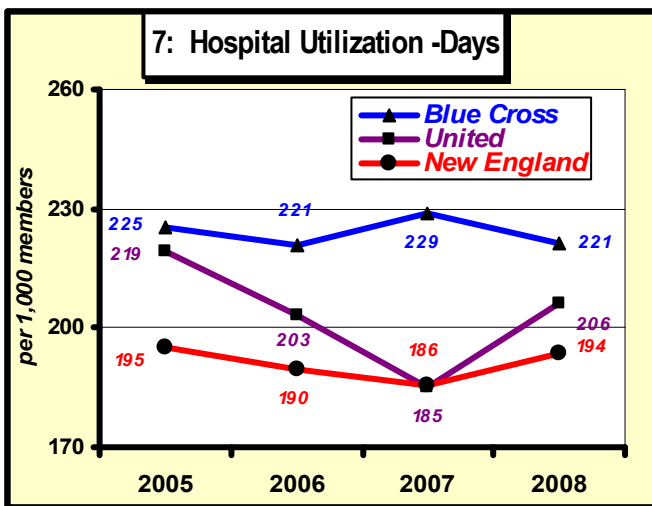
In 2008, Blue Cross' PMPM profits (\$1.33) were 76% below those in New England (\$5.50), and United's profits (\$22.40) were 307% above that comparable.

V: UTILIZATION

This section gives information⁴ on the services utilized by members in a health plan.

A. Hospital Utilization -Days are the average number of acute-care hospital days used by every 1,000 members in a plan (Chart 7). Excluded are substance abuse, mental health and nursery days.

Relatively high hospital day utilization rates are neither inherently favorable nor unfavorable, therefore, benchmarking to a desired goal (or trend) is not possible. Assuming that all hospital utilization is appropriate, then high day rates may be acceptable given a sicker population requiring more services. However, relatively high day rates could indicate a lack of preventive services or poor management of chronic diseases.

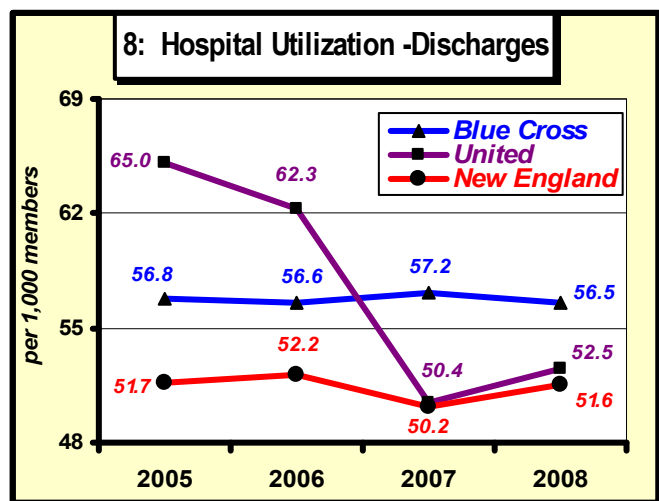


RI's two health plans consistently had higher hospital day utilization rates than their regional counterparts, but United reduced its utilization to slightly below that comparable in 2007. In 2008, Blue Cross ended 14% above the regional rate (221 vs. 194), and United was 7% above that comparable (206 vs. 194).

⁴ Measures in this section (i.e., utilization) are sourced from HEDIS data. HEDIS (Health Plan Employer Data and Information Set) is a set of performance measures for the health insurance industry, administered by the National Committee for Quality Assurance (NCQA). The values reported for Blue Cross-RI are a combined rate (i.e., sum of the numerators over the sum of the denominators) of the individual HEDIS rates reported for its commercial PPO and HMO products.

B. Hospital Utilization -Discharges are the average number of acute-care hospital discharges (excluding substance abuse, mental health and nursery discharges) per 1,000 members in a plan (Chart 8).

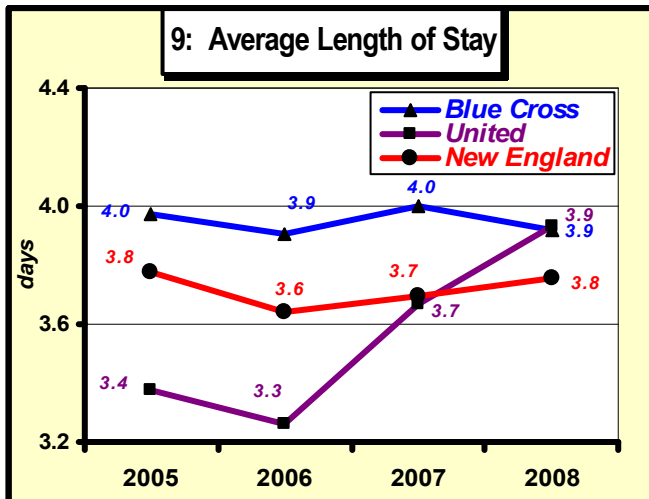
As with day utilization rates, relatively high discharge rates are neither inherently favorable nor unfavorable. Therefore, benchmarking to a desired goal (or trend) is not possible. Assuming that all hospital utilization is appropriate, then high discharge rates may be acceptable given a sicker population requiring more services.



Again, the two plans consistently had higher hospital discharge rates than their regional counterparts, but United reduced its utilization to a similar rate in 2007, while Blue Cross remained 14% above that comparable. In 2008, Blue Cross ended 10% above the regional rate (56.5 vs. 51.6), and United was 2% above that comparable (52.5 vs. 51.6).

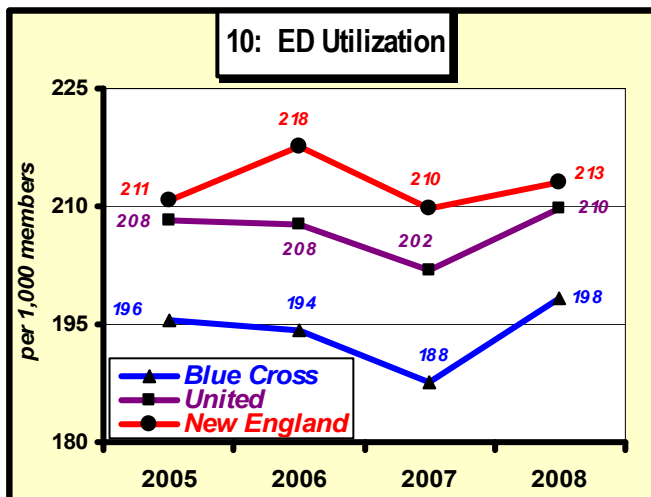
C. Average Length of Stay is the average number of inpatient days incurred for each acute-care hospital discharge (Chart 9).

Higher average length of stay (ALOS) values are neither inherently desirable nor undesirable without case-mix adjusting the different patient populations. A longer length of stay may be warranted because of the complexity of a particular plan's membership requiring more intensive inpatient services. Therefore, there is no desired trend or benchmark for this measure.



Blue Cross had ALOS values regularly above the regional values, and remained 4% above this comparable in 2008 (3.9 vs. 3.8 days). United, on the other hand, started the period below the regional value, and ended 5% above that comparable in 2008 (3.9 vs. 3.8 days).

D. ED Utilization is the number of visits to hospital emergency departments (excluding behavioral health visits and those that result in the patient being admitted for inpatient care) for every 1,000 members in a plan (Chart 10). Emergency departments are often used to provide primary or secondary care that could be delivered more inexpensively and more appropriately elsewhere. Therefore, lower values on this measure are preferred.



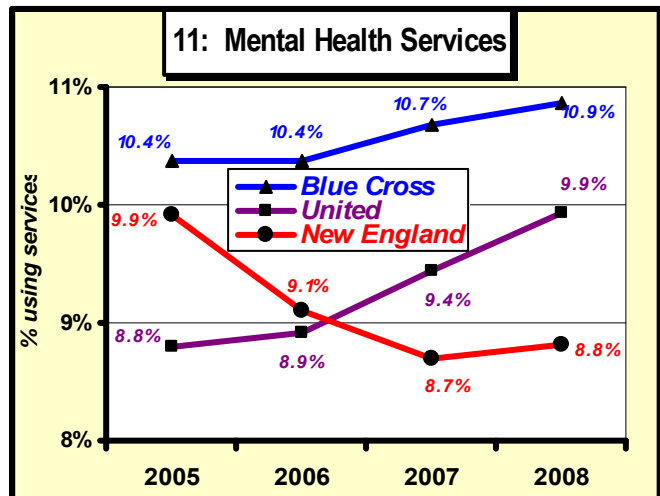
Blue Cross outperformed United by -5% on this measure in 2008. Both plans remained favorably below the N.E. averages over the period. In 2008, Blue Cross was 7% below that value (198

vs. 213), and United was 2% below that comparable (210 vs. 213).

Regardless of these favorable relative performances, neither plan approached the national benchmark in 2008. Blue Cross was 40% unfavorably above the benchmark of 142, and United was 48% above that value. RI clearly needs to expand its primary care delivery system to further reduce inappropriate ED utilization.

E. Mental Health Services is the percentage of members with a mental health benefit that received any mental health treatment (i.e., inpatient, intermediate or ambulatory) during the year (Chart 11).

Mental illness is widely under-diagnosed and a major quality-of-life determinant, thus an argument could be made that trends should be increasing. However, without knowing the respective disease incidences, one cannot conclude that a higher value is necessarily preferable to a lower one. Therefore, there is no desired trend or benchmark for this measure.



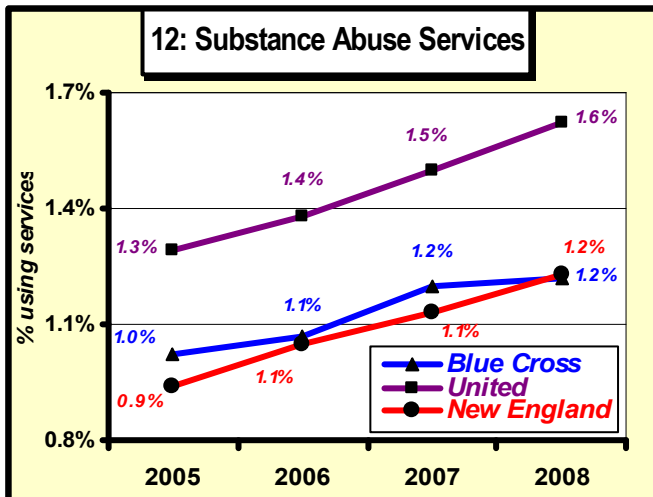
Absolute values for both plans rose over the period, while the regional averages fell. In 2008, Blue Cross ended 23% above the regional comparable (10.9% vs. 8.8%), and United was 13% above that value (9.9% vs. 8.8%).

Without evaluating the comparative mental illness incidence rates, the actual utilization of services, and outcomes, one cannot determine if mental health treatment was any better in one plan than another (or in RI than elsewhere). One may only state that a greater percentage of members in a

plan with a higher value accessed these services (at least once).

F. Substance Abuse Services is the percentage of members filing an alcohol and/or other drug claim for substance abuse treatment services (i.e., inpatient, day or outpatient) during the year (Chart 12).

Substance abuse is very expensive in terms of personal and societal costs. Treatment, even with recidivism, remains the most cost-effective response to this disease. However, as with mental illness, without knowing the respective disease incidences, one cannot conclude that a higher value is necessarily preferable to a lower one. Therefore, there is no desired trend or benchmark for this measure.



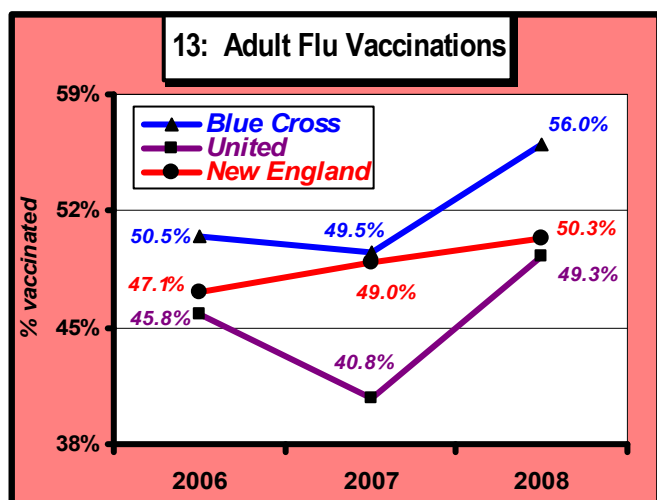
Absolute values for both plans rose over the period, with Blue Cross closely tracking the N.E. experience, and United consistently above those values. In 2008, Blue Cross ended 1% below the regional average, while United was 32% above that value.

However, and similar to the mental health services measure, without knowing the comparative substance abuse incidence rates, the utilization of services, and outcomes, one cannot conclude that substance abuse treatment was any better in one plan than another (or in RI than elsewhere). One may only state that a greater percentage of members in a plan with a higher value accessed these services (at least once).

V: PREVENTION

This section contains measures⁵ that look at how effectively a plan delivers preventive services to keep its members healthy.

A. Adult Flu Vaccinations is the percentage of members (aged 50-64) who received an influenza vaccination during the year (Chart 13). Every year, up to 20% of Americans contract influenza, with more than 200,000 people hospitalized for flu-related complications. Vaccination is the most effective way to prevent severe flu-related illness and death. Higher values on this measure are, therefore, preferred.



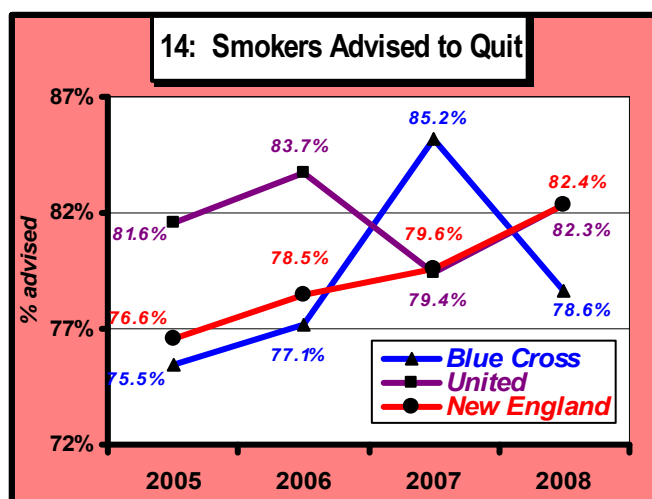
Blue Cross outperformed United by +14% on this measure in 2008. That year, Blue Cross was 11% above the regional average (56.0% vs. 50.3%), while United was essentially equivalent to that comparable (49.3% vs. 50.3%, less than a -5% variance).

Blue Cross approached the national benchmark in 2008 (56.0% vs. 58.1%, less than a -5% variance), and United was 15% below that cutoff (49.3% vs. 58.1%).

⁵ Measures in this section (i.e., prevention) are sourced from CAHPS data. CAHPS (Consumer Assessment of Healthcare Providers & Systems) is a set of standardized surveys administered by the NCQA. The values reported for Blue Cross-RI are a weighted-average (based on RI membership) of the individual CAHPS values reported for its commercial PPO and HMO products.

B. Smokers Advised to Quit is the percentage of members (ages 18+) who are smokers and received advice to quit within the past year (Chart 14). An estimated 21% of adult Americans are smokers and it is the leading preventable cause of death in the nation (~440,000 deaths per year). Seventy percent of smokers are interested in stopping, and getting advice to quit is associated with a 30% increase in success rates. Therefore, higher values on this measure are preferred.

This measure is tracked by the RI-DOH Tobacco Control Program⁶ as part of its efforts to reduce smoking in the state. Tobacco Control has adopted a goal of 95% compliance on this metric.



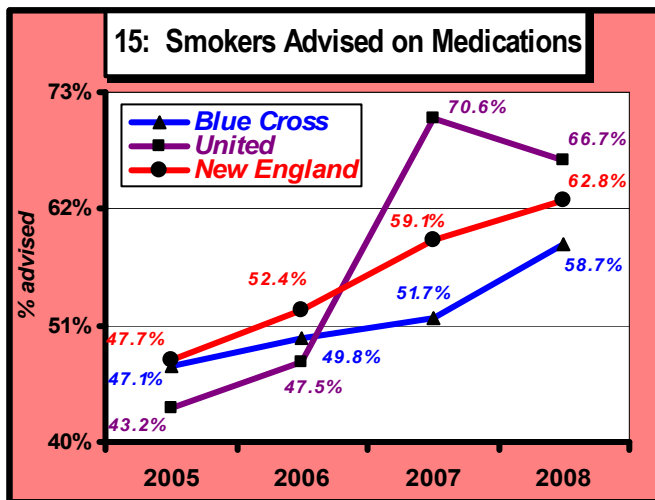
Plan performance on this measure was very erratic, both in absolute and relative terms. In 2008, Blue Cross ended 5% below the N.E. average (78.6% vs. 82.4%), while United ended essentially equivalent to that value (82.3% vs. 82.4%, less than a -5% variance).

In 2008, Blue Cross was 5% below the national benchmark (78.6% vs. 82.9%) and United was not significantly below that value (82.3% vs. 82.9%, less than a -5% variance).

C. Smokers Advised on (Cessation) Medications is the percentage of members (ages 18+) who are smokers and received advice on cessation medications (Chart 15). Research has shown that provider advice on cessation medications doubles quit rates. Therefore, higher values on this measure are preferred.

⁶ For more information, contact Seema Dixit, MPH, MS, at 401-222-7463, seema.dixit@health.ri.gov

This measure is also tracked by the RI-DOH Tobacco Control Program, and it has adopted a goal of 95% compliance on this metric.



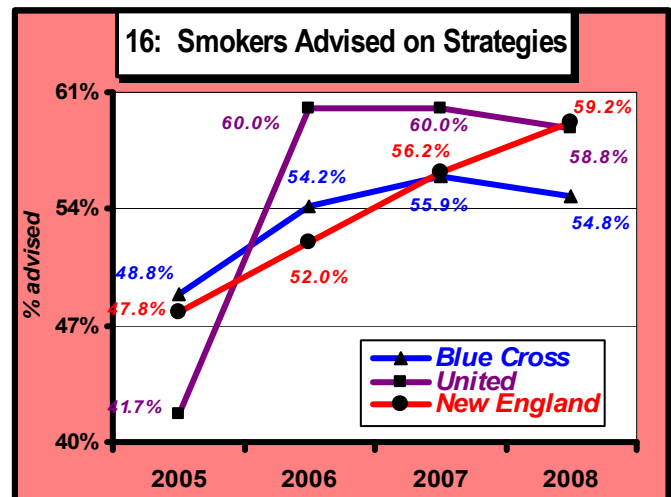
United outperformed Blue Cross by +14% on this measure in 2008. That year, Blue Cross was 7% below the regional average (58.7% vs. 62.8%), while United was 6% above that comparable (66.7% vs. 62.8%).

In 2008, Blue Cross was 7% below the national benchmark (58.7% vs. 63.0%), and United was 6% above that cutoff (66.7% vs. 63.0%), putting it among the best 10% of health plans nationally on this measure.

Irrespective of United's favorable performance, and given the marginal cost of providing medical advice on smoking, further gains should be made on a statewide basis when 41% of Blue Cross' and 33% of United's affected members were not properly advised on cessation medications.

D. Smokers Advised on (Cessation) Strategies is the percentage of members (ages 18+) who are smokers and received advice on cessation strategies (Chart 16). Due to the effectiveness of provider advice in routine clinical encounters, it is important that smokers are consistently advised on a combination of cessation strategies, including counseling and pharmacotherapy. Therefore, higher values on this measure are preferred.

This is a third measure tracked by the RI-DOH Tobacco Control Program, and it has adopted a goal of 95% compliance on this metric.



United outperformed Blue Cross by +7% on this measure in 2008. That year, Blue Cross was 7% below the N.E. average (54.8% vs. 59.2%), while United was essential equivalent to that comparable (58.8% vs. 59.2%, less than a -5% variance).

In 2008, Blue Cross was 6% below the national benchmark (54.8% vs. 58.2%, the national benchmark was below the regional average that year). United was above that cutoff value (58.8% vs. 58.2%), putting it among the best 10% of health plans nationally on this measure.

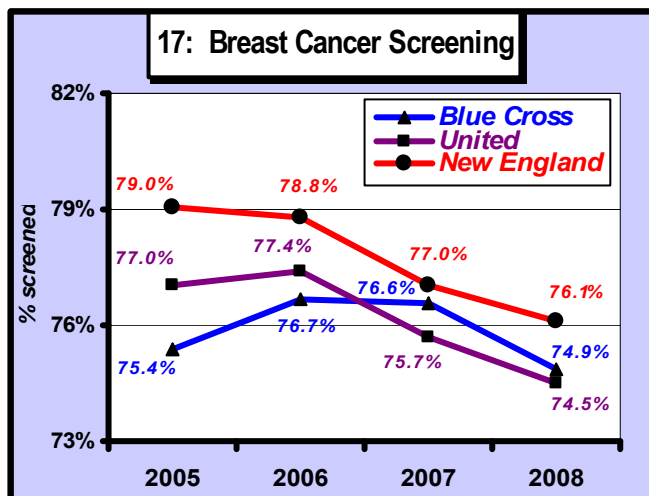
Once again, given the marginal cost of providing medical advice on smoking, further gains should be made on a statewide basis when over 40% of the affected members were not properly advised on cessation strategies.

VI: SCREENING

The measures⁷ in this section provide information on how effectively a health plan screens its members for possible medical problems. Screening is the second most cost-effective activity (behind prevention) to reduce the adverse effects of disease.

A. Breast Cancer Screening is the percentage of women members (ages 52-69) who had a mammogram within the last two years (Chart 17). Breast cancer is the second most prevalent cancer among U.S. women, with over 178,000 new cases per year resulting in ~40,000 deaths annually. Mammography screening reduces mortality rates by 30% for women 50 and older, so higher values on this measure are preferred.

This measure is tracked by the RI-DOH Women's Cancer Screening Program,⁸ which provides breast and cervical cancer screening to RI's uninsured, program-eligible women. Because the Program is targeted to the uninsured, it does not have an adopted goal for this measure, which reflects the commercially insured population only.

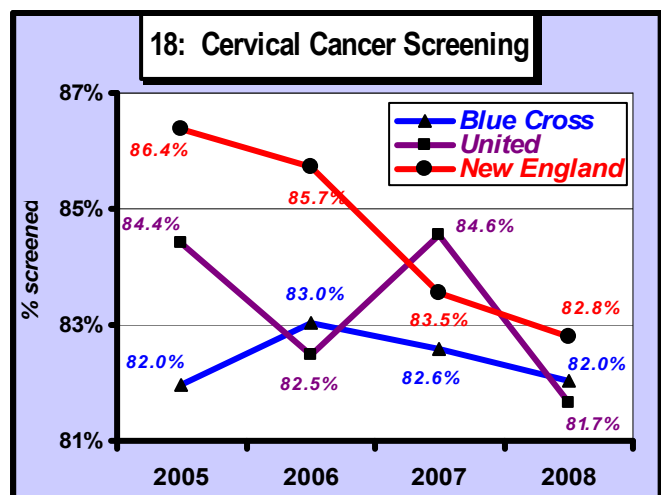


Local breast cancer screening rates declined over the period but finished relatively favorably. In 2008, neither Blue Cross nor United was signifi-

cantly different from the regional average of 76.1%, or the national benchmark of 76.8% (i.e., less than -5% variances for both).

B. Cervical Cancer Screening is the percentage of women (ages 21-64) who received a Pap test within three years (Chart 18). Cervical cancer is one of the most successfully treated cancers when diagnosed early, and screening has led to declining mortality rates over the past 30 years. Nonetheless, an estimated 11,000 new cases are diagnosed each year resulting in nearly 4,000 deaths nationally. Therefore, higher values on this measure are preferred.

This is another measure tracked by the RI-DOH Women's Cancer Screening Program. Because the Program is targeted to the uninsured, it does not have an adopted goal for this measure, which reflects the commercially insured population only.



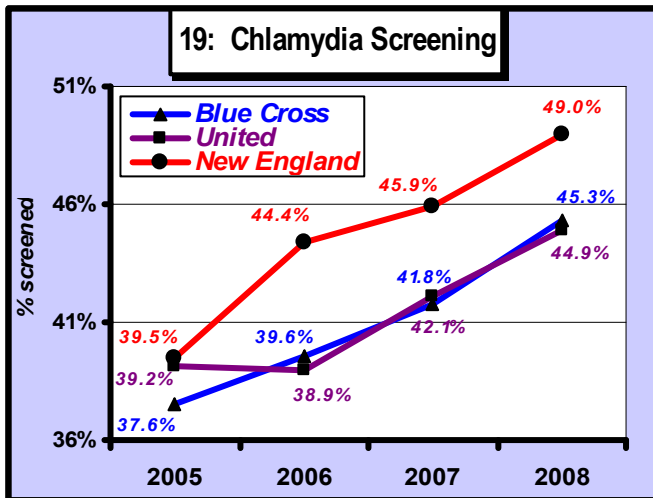
Local cervical cancer screening rates declined in 2008, but neither health plan deviated substantially from the regional average (82.8%), or the U.S. benchmark of 85.6% (i.e., less than -5% variances for both).

C. Chlamydia Screening is the percentage of (sexually active) women members (ages 16-25) who received a chlamydia test during the year (Chart 19). Chlamydia is a leading cause of infertility, and the most common sexually transmitted disease (STD) in the U.S. with approximately 2.8 million new infections per year. Screening is essential because the disease is usually asymptomatic and easily treated with antibiotics. Higher values on this measure are, therefore, preferred.

⁷ Measures in this section (i.e., screening) are sourced from HEDIS data. The values reported for Blue Cross-RI are a weighted-average (based on the eligible populations) of the individual HEDIS values reported for its commercial PPO and HMO products.

⁸ For more information, call the Program Information Line at 401-222-4324

The RI-DOH's STD Prevention and Control Program⁹ follows this measure to monitor Chlamydia screening in the commercially insured population. Because the Program targets the under/uninsured, it does not have an adopted goal for this measure (which reflects the commercially insured population only).



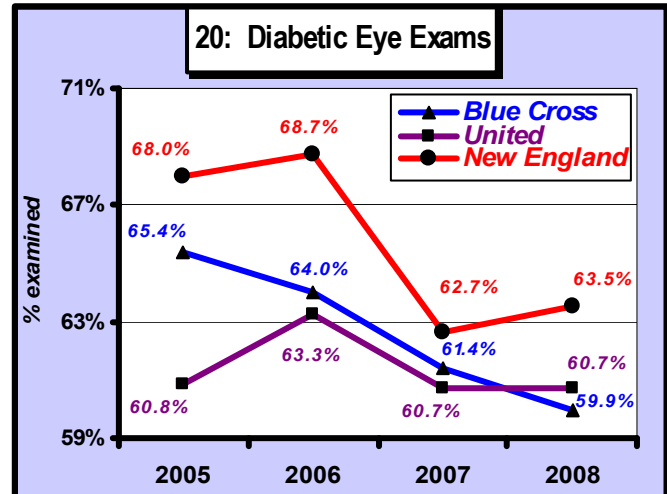
RI health plans improved their values on this measure, but the N.E. averages increased at a faster pace, compromising their relative performances. In 2008, both Blue Cross and United ended 8% below the regional average.

Neither plan approached the U.S. benchmark of 52.5% in 2008. Both Blue Cross and United were 14% below that cutoff value.

Regardless of the recent improvements in local chlamydia screening rates, the low absolute values illustrate the need for further improvement as ~55% of the affected members in these plans were not being evaluated.

D. Diabetic Eye Exams is the percentage of diabetic members (ages 18-75) that received an eye exam for retinal disease (Chart 20). Diabetes is the leading cause of adult blindness in the U.S., so regular examinations are important to diagnose and treat problems as early as possible. Therefore, higher values on this measure are preferred.

This is a measure tracked by the RI-DOH Diabetes Prevention and Control Program¹⁰ as part of its efforts to reduce the incidence of and improve the quality of care for the disease. The Program has adopted a goal of 85% for this measure.



In 2008, Blue Cross ended 6% below the N.E. average (59.9% vs. 63.5%), while United was not appreciably different from that comparable (60.7% vs. 63.5%, less than a -5% variance).

In 2008, Blue Cross was 14% below the national benchmark (59.9% vs. 69.8%) and United was 13% below that cutoff (60.7% vs. 69.8%).

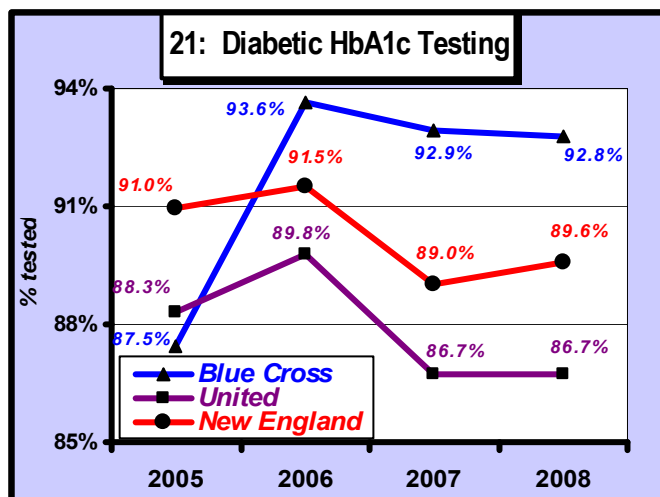
Given the low absolute values of both plans, eye exam screening rates should be improved when over 39% of the eligible members remain un-screened.

E. Diabetic HbA1c Testing is the percentage of diabetic members (ages 18-75) who had their hemoglobin A1c tested (Chart 21). Diabetes is one of the most costly (~\$100 billion annually), and prevalent diseases in the U.S. (~21 million persons), causing 20% of all deaths in adults over 25. Diabetic complications (amputations, kidney failure, blindness) may be prevented if diagnosed and addressed early, so higher values on this measure are preferred.

This is another measure tracked by the RI-DOH Diabetes Prevention and Control Program and it has adopted a target goal of 95% for HbA1c testing.

⁹ For more information contact Michael Gosciminiski, MPH, at 401-222-1365, michael.gosciminiski@health.ri.gov

¹⁰ For more information contact Dona Goldman, RN, MPH, at 401-222-6957, dona.goldman@health.ri.gov



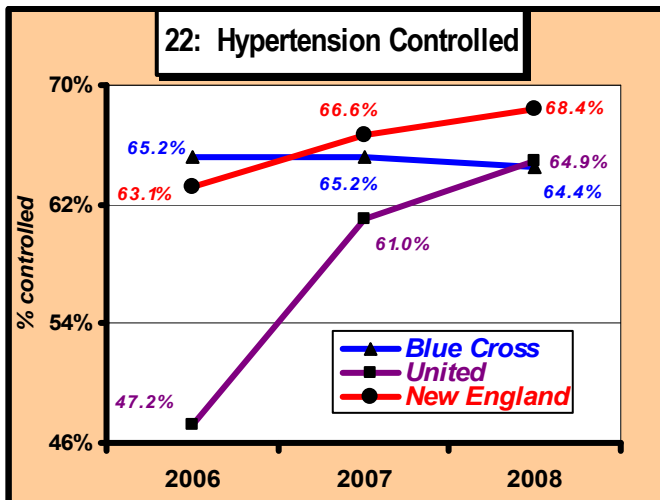
Blue Cross outperformed United by +7% on this measure in 2008. That year, neither plan deviated significantly from the regional average (i.e., less than $\pm 5\%$ variances).

In 2008, Blue Cross was among the best 10% of health plans nationally on this measure (92.8% vs. the U.S. benchmark of 92.7%), while United was 6% below that cutoff (86.7% vs. 92.7%).

VII: TREATMENT

This section contains measures¹¹ that look at the clinical quality of care provided within a health plan, including how well it treats its members who are ill and whether that care is effectively managing the underlying disease.

A. Hypertension Controlled is the percentage of hypertensive members (ages 46-85) whose blood pressure was under control (<140/90, Chart 22). Approximately 50% of adults over 45 have hypertension, and controlling this disease can reduce the incidence of stroke by 35%-40%, myocardial infarction by 20% -25%, and heart failure by 50%. Therefore, higher values on this measure are preferred.



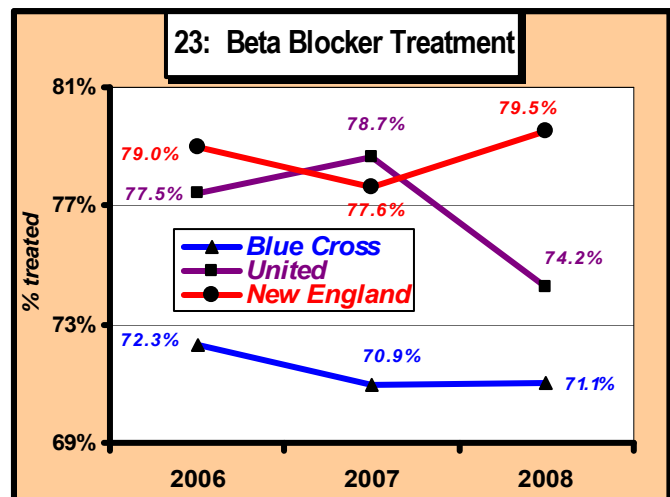
United improved its performance substantially over the period to end essentially equivalent to Blue Cross in 2008. That year, Blue Cross was 6% below the N.E. average (64.4% vs. 68.4%), and United was 5% below that comparable (64.9% vs. 68.4%).

In 2008, Blue Cross was 10% below the national benchmark (64.4% vs. 71.6%) and United was 9% below that cutoff (64.9% vs. 71.6%).

Regardless of the overall gains from 2006-2008, over 35% of the plans' affected members were not having this risk factor controlled.

B. Beta-Blocker Treatment is the percentage of members (18 and older) discharged after an acute myocardial infarction (AMI) who received persistent beta-blocker treatment for six months after discharge (Chart 23). Given the prevalence and costs of heart disease in the U.S. (i.e., over 1 million AMIs at a cost of ~\$111 billion, annually), beta-blocker therapy has proven an effective medical treatment to reduce the risk of having another attack. Higher values on this measure are, therefore, preferred.

This measure is tracked by the RI-DOH Heart Disease and Stroke Prevention Program¹² to improve the current heart disease and stroke prevention system in RI. The Program has adopted a goal of 100% compliance on this measure.



In 2008, Blue Cross ended 11% below the regional average (71.1% vs. 79.5%), and United ended 7% below that comparable (74.2% vs. 79.5%).

In 2008, Blue Cross was 16% below the national benchmark (71.1% vs. 84.6%) and United was 12% below that cutoff (74.2% vs. 84.6%).

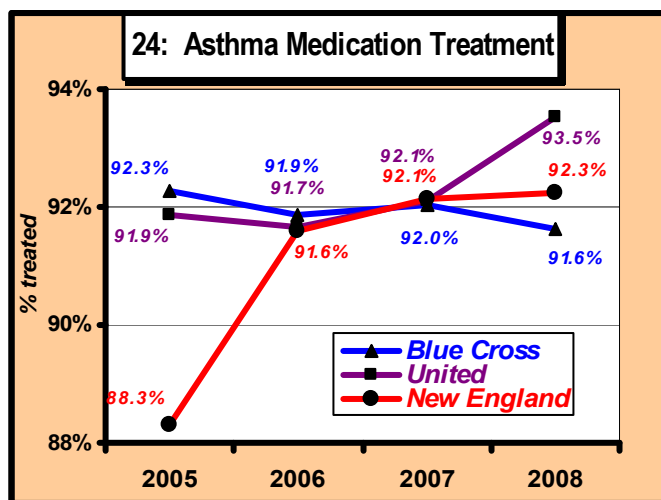
C. Asthma Medication Treatment is the percentage of persistent asthmatic members (ages 5-56) prescribed the appropriate medications during the year (Chart 24). Over 30 million Americans, including 8.5 million children, suffer from asthma.

¹¹ Measures in this section (i.e., treatment) are sourced from HEDIS data. The values reported for Blue Cross-RI are a weighted-average (based on the eligible populations) of the individual HEDIS values reported for its commercial PPO and HMO products.

¹² For more information contact Patricia Affleck, RN, at 401-222-7636, patricia.affleck@health.ri.gov

In RI, an estimated 10% of the population is affected, including 83,000 adults and 27,000 children. In 2005 and 2006, there were 1,511 hospital discharges where asthma was the primary diagnosis (in patients ages 5-56), 30% of which were covered by Blue Cross and United. Some of these admissions could have been avoided had the disease been more effectively managed. Higher values on this measure are, therefore, preferred.

This measure is tracked by the RI-DOH Asthma Control Program¹³ as part of its efforts to improve the quality of asthma care and patient education to, in part, reduce asthma hospitalizations. The Program has adopted a goal of 95% compliance on this measure.

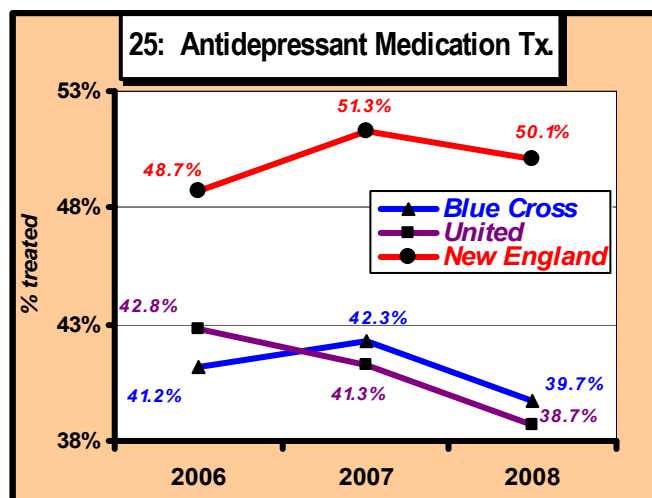


Both Blue Cross and United performed fairly well on this measure, with values virtually indistinguishable through 2007. In 2008, the values diverged, but remained within 2% of each other and essentially equivalent to the regional average (i.e., less than +/- 5% variances).

In 2008, neither plan differed significantly from the U.S. benchmark of 94.9% (i.e., less than -5% variances).

D. Antidepressant Medication Treatment is the percentage of members (ages 18+) with a new episode of major depression who received medication and remained on an antidepressant drug for at least 180 days (Chart 25). Almost 21 million Americans suffer from a depressive disorder annually, and it is a major quality of life factor, with

huge societal costs in terms of worker absenteeism and lost productivity. Therefore, higher values on this measure are preferred.



Both RI health plans performed poorly on this measure throughout the period. In 2008, Blue Cross ended 21% below the regional average (39.7% vs. 50.1%), and United was 23% below that value (37.8% vs. 50.1%).

Neither plan approached the U.S. benchmark of 54.4% in 2008. Blue Cross was 27% below that value, and United was 29% less.

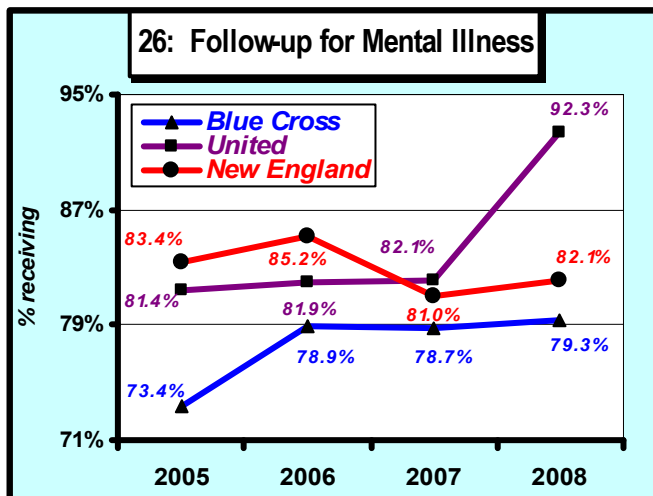
Improvement in managing depression is warranted, as over 60% of the affected members in both plans were not receiving or complying with the recommended treatment.

¹³ For more information contact Nancy Sutton, MS, RD, at 401-222-4040, nancy.sutton@health.ri.gov

VIII: ACCESS

The measures¹⁴ in this section examine if members are obtaining needed services from the healthcare system. Access is one of the most difficult concepts to gauge. It is more than simply making healthcare services available. Access means the right patients get the right care in the right amounts at the right time. Most of these measures are proxies for gauging access to particular services.

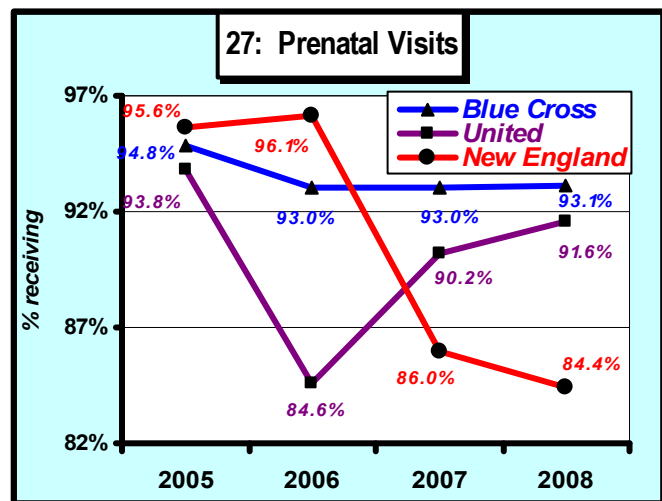
A. Follow-up for Mental Illness provides the percentage of members (ages 6+) who were discharged from hospitals for mental health treatment and received a follow-up visit within 30 days (Chart 26). Mental disorders affect about 25% of adult Americans, and most have their onset in childhood and adolescence. They are also a leading factor in suicides. Follow-up to hospitalization is important in transitioning the patient out of the inpatient setting and for evaluating medications, so higher values on this measure are preferred.



United outperformed Blue Cross by +16% on this measure in 2008. That year, Blue Cross was essentially similar to the regional average (i.e., less than a -5% variance), while United was 12% above that comparable.

In 2008, United was among the best 10% of health plans nationally on this measure (92.3% vs. the U.S. benchmark of 86.0%), while Blue Cross was 8% below that cutoff (79.3% vs. 86.0%).

B. Prenatal Visits measures the percentage of women who delivered a live birth and had a prenatal visit in the first trimester (Chart 27). Prenatal care is preventive care, both in terms of avoiding poor outcomes and preparing the woman to become a mother. Higher values on this measure are, therefore, preferred.

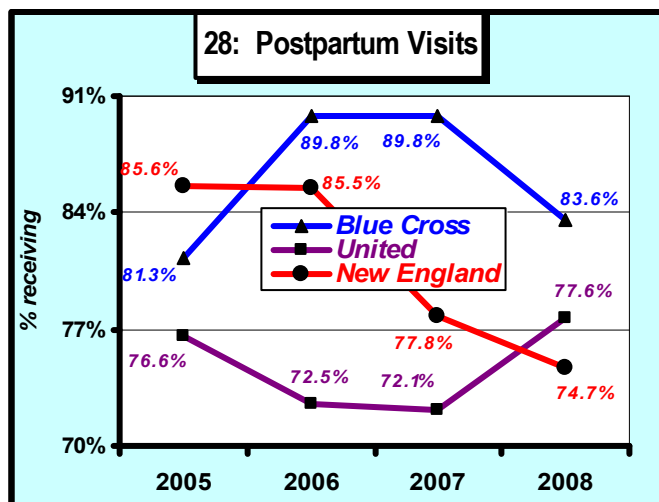


Regional averages on this measure declined precipitously from 2006, while local values increased or held steady. Consequently, both plans beat the N.E. comparable in 2008 (10% and 8% higher for Blue Cross and United, respectively).

In 2008, the U.S. benchmark was 97.1%, and Blue Cross was not significantly below that value (i.e., less than a -5% variance), and United was 6% below that cutoff.

C. Postpartum Visits measures the percentage of women who delivered a live birth and had a postpartum visit between 21-56 days after delivery (Chart 28). Postpartum care is essential in terms of evaluating the mother's physical and emotional well-being at a time of great stress and change. Therefore, higher values on this measure are preferred.

¹⁴ Measures in this section (i.e., access) are sourced from HEDIS data. The values reported for Blue Cross-RI are a weighted-average (based on the eligible populations) of the individual HEDIS values reported for its commercial PPO and HMO products.

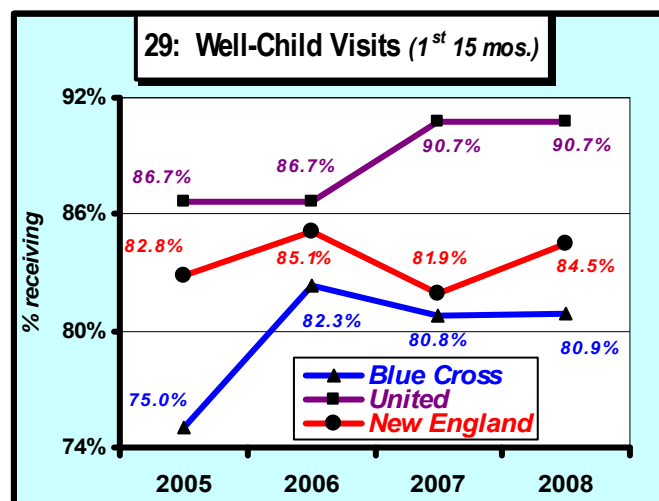


Blue Cross outperformed United by +8% on this measure in 2008. That year, Blue Cross was 12% above the N.E. average, while United was similar to that comparable (i.e., less than a +5% variance).

In 2008, Blue Cross was 6% below the national benchmark (83.6% vs. 89.0%) and United was 13% below that cutoff (77.6% vs. 89.0%).

D. Well-Child Visits (1st 15 mos.) measures the percentage of members (to 15 mos.) who received six or more primary care visits during the year (Chart 29). Early primary care allows an opportunity for a child's developmental delay or disability to be detected. This can lead to treatment, which lessens the future impact on both the child and family. In addition, primary care provides parents guidance in basic areas of childrearing. Higher values on this measure are, therefore, preferred.

This measure is tracked by the RI-DOH Perinatal and Early Childhood Health Team¹⁵ as part of its efforts to promote health among children (birth to 6 years), and their families. The various programs within the Team target individual provider practices, so they have no adopted target level for this measure of statewide performance.



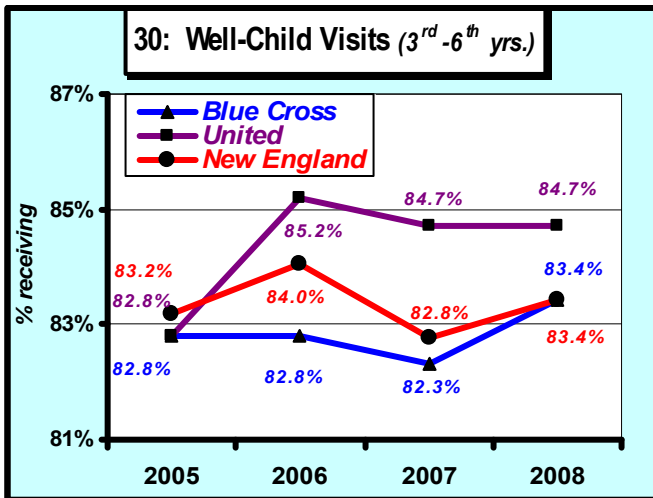
United outperformed Blue Cross by +12% on this measure in 2008. That year, Blue Cross was similar to the N.E. average (i.e., less than a -5% variance), while United was 7% above that comparable.

The U.S. benchmark was 87.4% in 2007. Blue Cross was 8% below that threshold, while United was among the best 10% of health plans across the nation in this measure.

E. Well-Child Visits (3-6 yrs.) measures the percentage of members (ages 3-6) who received a primary care visit during the year (Chart 30). Well-child visits are critical in detecting vision, speech and language problems early to help each child reach his or her full potential. Therefore, higher values on this measure are preferred.

This measure is also tracked by the RI-DOH Perinatal and Early Childhood Health Team as part of its efforts to promote health among children (birth to 6 years), and their families. The various programs within the Team target individual provider practices, so they have no adopted target for this measure of statewide performance.

¹⁵ For more information contact Blythe Berger, ScD, at 401-222-5949, blythe.berger@health.ri.gov

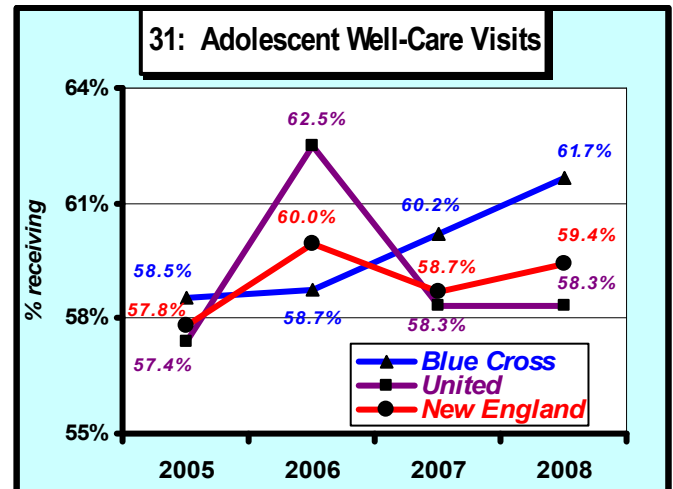


RI health plans performed well on this measure, ending essentially equivalent to the regional average in 2008 (i.e., less than +5% variances).

The national benchmark was 83.2% in 2008 (i.e., less than the N.E. average). Both Blue Cross and United were among the best 10% of health plans in the U.S. on this measure.

F. Adolescent Well-Care Visits measures the percentage of members (ages 12-21) who received a comprehensive well-care visit during the year (Chart 31). Well-care visits are key to addressing the physical, emotional and social aspects of development in this population transitioning from childhood to adulthood. Therefore, higher values on this measure are preferred.

This measure is tracked by the RI-DOH Adolescent Health Program¹⁶ as part of its efforts to improve the health of adolescents through the development of medical homes. The Program has adopted a goal of 75% compliance on this measure.



Blue Cross outperformed United by +6% on this measure in 2008. That year, neither plan was appreciably different from the regional average of 59.4% (i.e., less than +/-5% variances).

The U.S. benchmark was 59.6% in 2008. Blue Cross was among the best 10% of health plans nationally on this measure, while United was not appreciably below that cutoff (i.e., less than a -5% variance).

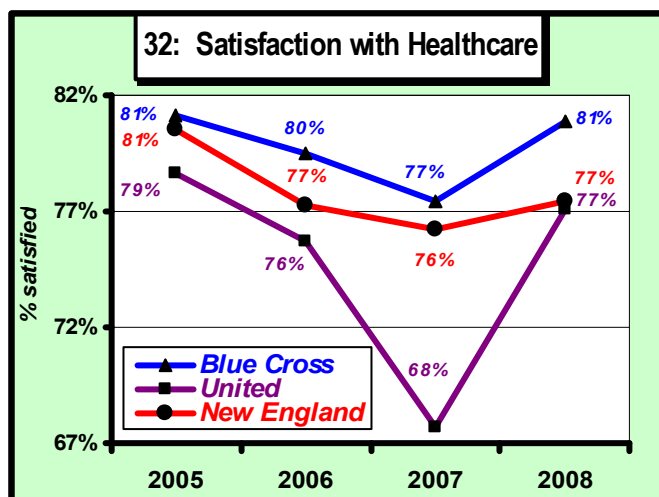
Regardless of the favorable, relative performances of both health plans, over 38% of their eligible members were not accessing these services on a timely basis.

¹⁶ For more information contact Rosemary Reilly-Chammat, Ed.D, at 401-222-5922, rosemary.reilly-chammat@health.ri.gov

IX: SATISFACTION

The measures¹⁷ in this section give information on the percentage of members who were satisfied with their healthcare experience, including both the services provided and the health plan itself.

A. Satisfaction with Healthcare is the percentage of members rating the healthcare services received in the past year as “excellent” or “very good” (Chart 32). This is a significant satisfaction measure in that it provides a composite score of overall satisfaction with all of the healthcare services a member receives. Perception is an important aspect of quality in that members must believe they are receiving quality services for them to be effectively provided, so higher values are preferred.

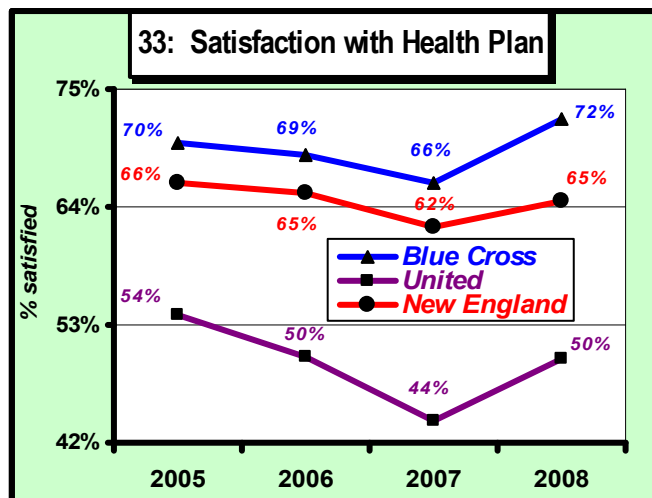


Both Blue Cross and United scored well on their healthcare satisfaction measures in 2008. That year, the plans did not differ significantly from each other or from the regional average of 77.4% (i.e., less than +/- 5% variances).

The national benchmark was 80.9% in 2008, and neither plan was appreciable different than that value (i.e., less than -5% variances).

B. Satisfaction with Health Plan is the percentage of members rating the health plan as “excel-

lent” or “very good” (Chart 33). This is another composite measure of satisfaction examining how members viewed the health plan itself. This measure and the previous one may be used as marketing and improvement tools indicating how the so-called ‘customers’ view the ‘product’. Therefore, higher values are preferred.

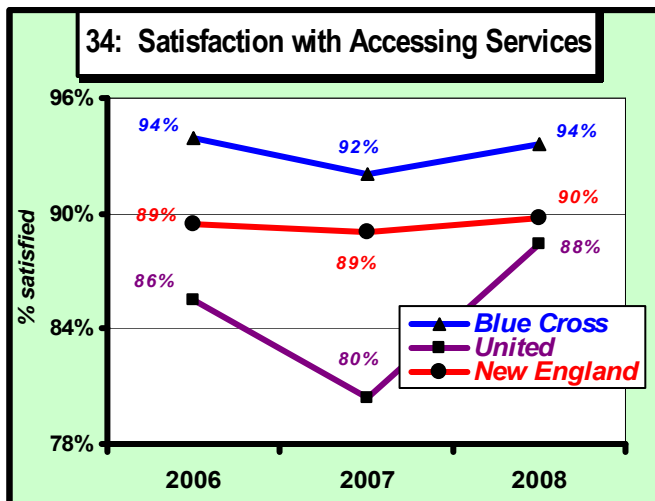


Blue Cross outperformed United by +45% on this measure in 2008. That year, Blue Cross was 12% above the N.E. average, while United was 23% below that value.

In 2008, Blue Cross was not significantly below the national benchmark (72.2% vs. 74.2%), while United was 33% below that cutoff (49.9% vs. 74.2%).

C. Satisfaction with Accessing Services is the percentage of members responding they were “usually” or “always” able to access the healthcare services they thought they needed in the past year (Chart 34). Higher values on this measure are preferred.

¹⁷ Measures in this section (i.e., satisfaction) are sourced from CAHPS data. The values reported for Blue Cross -RI are a weighted-average (based on RI membership) of the individual CAHPS values reported for its commercial PPO and HMO products.



Blue Cross outperformed United by +6% on this measure in 2008. That year, neither plan was significantly different from the regional average of 89.7% (i.e., less than +/-5% variances).

The national benchmark was 92.5% in 2008. Blue Cross was among the best 10% of plans nationally on this measure, while United was not appreciably different than that value (i.e., less than a -5% variance).

APPENDIX A: Blue Cross -RI (Commercial Data)					
	2005	2006	2007	2008	
ENROLLMENT					
1 RI Commercial Enrollment (RI member months/12)	228,824	221,650	213,271	191,050	
2 RI Commercial Market Shares [*]	64.9%	64.8%	63.0%	64.5%	
COSTS					
3 Premiums (per member per month)	\$301.94 ¹	\$316.72 ¹	\$333.24 ¹	\$353.84 ¹	
4 Medical Expenses (per member per month)	\$258.49 ¹	\$269.67 ¹	\$282.21 ¹	\$295.02 ¹	
5 Administrative Expenses (per member per month)	\$36.13 ¹	\$38.57 ¹	\$44.44 ¹	\$57.50 ¹	
6 Profits (per member per month)	\$7.32 ¹	\$8.48 ¹	\$6.59 ¹	\$1.33 ¹	
UTILIZATION					
7 Hospital Days (per 1,000 members)	225.4 ²	220.8 ²	228.8 ²	221.4 ²	
8 Hospital Discharges (per 1,000 members)	56.8 ²	56.6 ²	57.2 ²	56.5 ²	
9 Average Length of Stay	3.97 ²	3.90 ²	4.00 ²	3.92 ²	
10 ED Visits (per 1,000 members)	195.6 ²	194.1 ²	187.7 ²	198.2 ²	
11 Mental Health Services (% accessing care)	10.4% ²	10.4% ²	10.7% ²	10.9% ²	
12 Substance Abuse Services (% accessing care)	1.02% ²	1.07% ²	1.20% ²	1.22% ²	
PREVENTION					
13 Childhood Immunization (combo 2; to 2 yrs.)	79.8% ³	79.8% ^{3,5}	85.4% ³	85.4% ^{3,5}	
14 Adult Flu Vaccinations (50-64 yrs., Q.44)	---	50.5% ⁴	49.5% ⁴	56.0% ⁴	
15 Smokers Advised to Quit (18+ yrs., Q.46)	75.5% ⁴	77.1% ⁴	85.2% ⁴	78.6% ⁴	
16 Smoking Cessation Meds Discussed (18+ yrs., Q.47)	47.1% ⁴	49.8% ⁴	51.7% ⁴	58.7% ⁴	
17 Smoking Cessation Strategy Discussed (18+ yrs., Q.48)	48.8% ⁴	54.2% ⁴	55.9% ⁴	54.8% ⁴	
SCREENING					
18 Colorectal Cancer Screening (51-80 yrs.)	62.3% ³	62.8% ³	66.7% ³	66.7% ^{3,5}	
19 Breast Cancer Screening (52-69 yrs.)	75.4% ³	76.7% ³	76.6% ³	74.9% ³	
20 Cervical Cancer Screening (21-64 yrs.)	82.0% ³	83.0% ³	82.6% ³	82.0% ³	
21 Chlamydia Screening (16-24 yrs.)	37.6% ³	39.6% ³	41.8% ³	45.3% ³	
22 Diabetic Eye Exams (18-75 yrs.)	65.4% ³	64.0% ³	61.4% ³	59.9% ³	
23 Diabetic HbA1c Testing (18-75 yrs.)	87.5% ³	93.6% ³	92.9% ³	92.8% ³	
TREATMENT					
24 Hypertension Controlled (<140/90; 18-85 yrs.)	---	65.2% ³	65.2% ^{3,5}	64.4% ³	
25 Persistent Beta Blocker Treatment (after AMI; 18+ yrs.)	---	72.3% ³	70.9% ³	71.1% ³	
26 Cholesterol Controlled (LDL-C<100 mg/dL; 18-75 yrs.)	---	59.1% ³	61.4% ³	61.4% ^{3,5}	
27 Appropriate Asthma Medications (5-56 yrs.)	92.3% ³	91.9% ³	92.0% ³	91.6% ³	
28 Antidepressant Med. Mgmt. (continuation phase; 18+ yrs.)	---	41.2% ³	42.3% ³	39.7% ³	
ACCESS					
29 Follow-up for Mental Illness (w/in 30 days; 6+ yrs.)	73.4% ³	78.9% ³	78.7% ³	79.3% ³	
30 Prenatal Visits (w/in 1 st trimester)	94.8% ^{3,5}	93.0% ³	93.0% ^{3,5}	93.1% ³	
31 Postpartum Visits (w/in 21-56 days)	81.3% ^{3,5}	89.8% ³	89.8% ^{3,5}	83.6% ³	
32 Well-Child Visits (1 st 15 months; 6+ visits)	75.0% ³	82.3% ³	80.8% ³	80.9% ³	
33 Well-Child Visits (3 rd -6 th years)	82.8% ³	82.8% ³	82.3% ³	83.4% ³	
34 Adolescent Well-Care Visits	58.5% ³	58.7% ³	60.2% ³	61.7% ³	
SATISFACTION					
35 Satisfaction with Healthcare (Q.12; #s8-10)	81.1% ⁴	79.5% ⁴	77.5% ⁴	80.8% ⁴	
36 Satisfaction with Health Plan (Q.42; #s8-10)	70.0% ⁴	68.9% ⁴	66.3% ⁴	72.2% ⁴	
37 Ease of Accessing Services (Q.27)	---	93.9% ⁴	92.0% ⁴	93.6% ⁴	

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by the RI-DOH

^{*} Total RI commercial enrollment is based on an extrapolation from the quarterly filings to the RI-DOH's Office of Managed Care Regulation

¹ Source: RI Department of Business Regulation (Jack Broccoli, Chief Insurance Examiner, 401-462-9606); extracted from the NAIC Health Database

² Sourced from HEDIS data, a combined rate (i.e., sum of the numerators over sum of the denominators) for Blue Cross' commercial PPO and HMO products

³ Sourced from HEDIS data, a weighted-average (based on the eligible populations) of the values for Blue Cross' commercial PPO and HMO products

⁴ Sourced from CAHPS data, a weighted-average (based on the RI commercial enrollments) of the values for Blue Cross' commercial PPO and HMO products

⁵ Plan "rotated" the measure(s) (i.e., reported the previous year's value as allowed by the NCQA)

APPENDIX B: UnitedHealthcare -NE (Commercial Data)				
	2005	2006	2007	2008
ENROLLMENT				
1 RI Commercial Enrollment (RI member months/12)	59,140	49,891	42,178	35,025
2 RI Commercial Market Shares [*]	16.8%	14.6%	12.5%	11.8%
COSTS				
3 Premiums (per member per month)	\$287.84 ¹	\$305.18 ¹	\$325.30 ¹	\$338.03 ¹
4 Medical Expenses (per member per month)	\$224.10 ¹	\$234.57 ¹	\$257.36 ¹	\$263.43 ¹
5 Administrative Expenses (per member per month)	\$50.96 ¹	\$55.54 ¹	\$62.15 ¹	\$52.20 ¹
6 Profits (per member per month)	\$12.78 ¹	\$15.07 ¹	\$5.80 ¹	\$22.40 ¹
UTILIZATION				
7 Hospital Days (per 1,000 members)	219.5	203.2	184.8	206.4
8 Hospital Discharges (per 1,000 members)	65.0	62.3	50.4	52.5
9 Average Length of Stay	3.37	3.26	3.67	3.93
10 ED Visits (per 1,000 members)	208.2	207.8	202.0	209.7
11 Mental Health Services (% accessing care)	8.8%	8.9%	9.4%	9.9%
12 Substance Abuse Services (% accessing care)	1.29%	1.38%	1.50%	1.62%
PREVENTION				
13 Childhood Immunization (combo 2; to 2 yrs.)	79.6%	78.6%	83.3%	83.3% ²
14 Adult Flu Vaccinations (50-64 yrs., Q.44)	---	45.8%	40.8%	49.3%
15 Smokers Advised to Quit (18+ yrs., Q.46)	81.6%	83.7%	79.4%	82.3%
16 Smoking Cessation Meds Discussed (18+ yrs., Q.47)	43.2%	47.5%	70.6%	66.7%
17 Smoking Cessation Strategy Discussed (18+ yrs., Q.48)	41.7%	60.0%	60.0%	58.8%
SCREENING				
18 Colorectal Cancer Screening (51-80 yrs.)	61.1%	61.1% ²	57.9%	57.9% ²
19 Breast Cancer Screening (52-69 yrs.)	77.0%	77.4%	75.7%	74.5%
20 Cervical Cancer Screening (21-64 yrs.)	84.4%	82.5%	84.6%	81.7%
21 Chlamydia Screening (16-24 yrs.)	39.2%	38.9%	42.1%	44.9%
22 Diabetic Eye Exams (18-75 yrs.)	60.8%	63.3%	60.7%	60.7% ²
23 Diabetic HbA1c Testing (18-75 yrs.)	88.3%	89.8%	86.7%	86.7% ²
TREATMENT				
24 Hypertension Controlled (<140/90; 18-85 yrs.)	---	47.2%	61.0%	64.9%
25 Persistent Beta Blocker Treatment (after AMI; 18+ yrs.)	---	77.5%	78.7%	74.2%
26 Cholesterol Controlled (LDL-C<100 mg/dL; 18-75 yrs.)	---	54.0%	56.5%	56.5% ²
27 Appropriate Asthma Medications (5-56 yrs.)	91.9%	91.7%	92.1%	93.5%
28 Antidepressant Med. Mgmt. (continuation phase; 18+ yrs.)	---	42.8%	41.3%	38.7%
ACCESS				
29 Follow-up for Mental Illness (w/in 30 days; 6+ yrs.)	81.4%	81.9%	82.1%	92.3%
30 Prenatal Visits (w/in 1 st trimester)	93.8%	84.6%	90.2%	91.6%
31 Postpartum Visits (w/in 21-56 days)	76.6% ²	72.5%	72.1%	77.6%
32 Well-Child Visits (1 st 15 months; 6+ visits)	86.7%	86.7% ²	90.7%	90.7% ²
33 Well-Child Visits (3 rd -6 th years)	82.8%	85.2%	84.7%	84.7% ²
34 Adolescent Well-Care Visits	57.4%	62.5%	58.3%	58.3% ²
SATISFACTION				
35 Satisfaction with Healthcare (Q.12; #s8-10)	78.7%	75.7%	67.7%	77.1%
36 Satisfaction with Health Plan (Q.42; #s8-10)	53.9%	50.0%	44.0%	49.9%
37 Ease of Accessing Services (Q.27)	---	85.5%	80.4%	88.5%

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^{*} Total RI commercial enrollment is based on an extrapolation from the quarterly filings to the RI-DOH's Office of Managed Care Regulation

¹ Source: RI Department of Business Regulation (Jack Broccoli, Chief Insurance Examiner, 401-462-9606); extracted from the NAIC Health Database

² Plan "rotated" the measure (i.e., reported the previous year's value as allowed by the NCQA)

APPENDIX C: Blue Cross -MA (Commercial Data)				
	2005	2006	2007	2008
ENROLLMENT				
1 RI Commercial Enrollment (RI member months/12)	33,557	34,850	33,866	24,888
2 RI Commercial Market Shares [*]	9.5%	10.2%	10.0%	8.4%
COSTS				
3 Premiums (per member per month)	\$299.01 ¹	\$327.07 ¹	\$352.69 ¹	\$370.79 ¹
4 Medical Expenses (per member per month)	\$265.02 ¹	\$288.93 ¹	\$313.58 ¹	\$332.94 ¹
5 Administrative Expenses (per member per month)	\$33.99 ¹	\$38.14 ¹	\$40.46 ¹	\$42.69 ¹
6 Profits (per member per month)	\$5.57 ¹	\$1.47 ¹	(\$1.35) ¹	(\$4.85) ¹
UTILIZATION				
7 Hospital Days (per 1,000 members)	214.4	211.0	214.9	208.9
8 Hospital Discharges (per 1,000 members)	51.9	53.6	53.7	52.3
9 Average Length of Stay	4.13	3.94	4.00	4.00
10 ED Visits (per 1,000 members)	208.7	214.4	216.5	230.5
11 Mental Health Services (% accessing care)	11.1%	11.5%	11.7%	12.0%
12 Substance Abuse Services (% accessing care)	1.07%	1.24%	1.31%	1.51%
PREVENTION				
13 Childhood Immunization (combo 2; to 2 yrs.)	83.5%	87.3%	87.8%	89.9%
14 Adult Flu Vaccinations (50-64 yrs., Q.44)	---	49.0%	52.3%	52.5%
15 Smokers Advised to Quit (18+ yrs., Q.46)	79.7%	85.3%	80.3%	80.3%
16 Smoking Cessation Meds Discussed (18+ yrs., Q.47)	46.8%	54.8%	57.3%	55.3%
17 Smoking Cessation Strategy Discussed (18+ yrs., Q.48)	46.1%	50.0%	55.0%	56.2%
SCREENING				
18 Colorectal Cancer Screening (51-80 yrs.)	68.5%	69.4%	69.2%	76.3%
19 Breast Cancer Screening (52-69 yrs.)	82.2%	82.3%	81.4%	80.6%
20 Cervical Cancer Screening (21-64 yrs.)	87.8%	86.9%	86.9% ²	89.4%
21 Chlamydia Screening (16-24 yrs.)	46.7%	49.1%	50.7%	55.7%
22 Diabetic Eye Exams (18-75 yrs.)	74.7%	76.6%	75.4%	75.4% ²
23 Diabetic HbA1c Testing (18-75 yrs.)	93.2%	92.7%	92.9%	91.0%
TREATMENT				
24 Hypertension Controlled (<140/90; 18-85 yrs.)	---	68.4%	70.3%	69.5%
25 Persistent Beta Blocker Treatment (after AMI; 18+ yrs.)	---	84.3%	84.0%	82.9%
26 Cholesterol Controlled (LDL-C<100 mg/dL; 18-75 yrs.)	---	64.2%	69.5%	69.5% ²
27 Appropriate Asthma Medications (5-56 yrs.)	89.0%	89.6%	89.9%	90.2%
28 Antidepressant Med. Mgmt. (continuation phase; 18+ yrs.)	---	52.2%	52.0%	49.7%
ACCESS				
29 Follow-up for Mental Illness (w/in 30 days; 6+ yrs.)	85.5%	87.5%	85.3%	84.4%
30 Prenatal Visits (w/in 1 st trimester)	98.0% ²	100.0%	100.0% ²	96.5%
31 Postpartum Visits (w/in 21-56 days)	91.3% ²	89.8%	89.8% ²	88.4%
32 Well-Child Visits (1 st 15 months; 6+ visits)	95.4%	95.4% ²	94.8%	97.8%
33 Well-Child Visits (3 rd -6 th years)	92.4%	97.3%	92.4%	93.5%
34 Adolescent Well-Care Visits	71.9%	71.9% ²	76.3%	76.3% ²
SATISFACTION				
35 Satisfaction with Healthcare (Q.12; #s8-10)	80.4%	75.3%	75.6%	74.9%
36 Satisfaction with Health Plan (Q.42; #s8-10)	75.7%	70.2%	73.3%	70.4%
37 Ease of Accessing Services (Q.27)	---	92.2%	92.4%	89.0%

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by the RI-DOH

^{*} Total RI commercial enrollment is based on an extrapolation from the quarterly filings to the RI-DOH's Office of Managed Care Regulation

¹ Source: RI Department of Business Regulation (Jack Broccoli, Chief Insurance Examiner, 401-462-9606); extracted from the NAIC Health Database and an aggregate of the commercial product-lines of BCBS of MA, and BCBS of MA HMO Blue, Inc.

² Plan "rotated" the measure (i.e., reported the previous year's value as allowed by the NCQA)

APPENDIX D: New England Commercial Averages ¹				
	2005	2006	2007	2008
ENROLLMENT				
1 RI Commercial Enrollment (RI member months/12)	---	---	---	---
2 RI Commercial Market Shares	---	---	---	---
COSTS				
3 Premiums (per member per month)	\$317.14 ²	\$324.50 ²	\$378.53 ²	\$364.83 ²
4 Medical Expenses (per member per month)	\$264.85 ²	\$274.45 ²	\$323.91 ²	\$316.77 ²
5 Administrative Expenses (per member per month)	\$38.05 ²	\$40.45 ²	\$45.53 ²	\$42.57 ²
6 Profits (per member per month)	\$14.24 ²	\$9.60 ²	\$9.09 ²	\$5.50 ²
UTILIZATION				
7 Hospital Days (per 1,000 members)	195.2	189.8	185.8	193.6
8 Hospital Discharges (per 1,000 members)	51.7	52.2	50.2	51.6
9 Average Length of Stay	3.78	3.64	3.70	3.75
10 ED Visits (per 1,000 members)	210.8	217.6	209.6	213.1
11 Mental Health Services (% accessing care)	9.9%	9.1%	8.7%	8.8%
12 Substance Abuse Services (% accessing care)	0.94%	1.05%	1.13%	1.23%
PREVENTION				
13 Childhood Immunization (combo 2; to 2 yrs.)	81.2%	82.3%	73.5%	73.1%
14 Adult Flu Vaccinations (50-64 yrs., Q.44)	---	47.1%	49.0%	50.3%
15 Smokers Advised to Quit (18+ yrs., Q.46)	76.6%	78.5%	79.6%	82.4%
16 Smoking Cessation Meds Discussed (18+ yrs., Q.47)	47.7%	52.4%	59.1%	62.8%
17 Smoking Cessation Strategy Discussed (18+ yrs., Q.48)	47.8%	52.0%	56.2%	59.2%
SCREENING				
18 Colorectal Cancer Screening (51-80 yrs.)	63.6%	64.9%	63.3%	63.2%
19 Breast Cancer Screening (52-69 yrs.)	79.0%	78.8%	77.0%	76.1%
20 Cervical Cancer Screening (21-64 yrs.)	86.4%	85.7%	83.5%	82.8%
21 Chlamydia Screening (16-24 yrs.)	39.5%	44.4%	45.9%	49.0%
22 Diabetic Eye Exams (18-75 yrs.)	68.0%	68.7%	62.7%	63.5%
23 Diabetic HbA1c Testing (18-75 yrs.)	91.0%	91.5%	89.0%	89.6%
TREATMENT				
24 Hypertension Controlled (<140/90; 18-85 yrs.)	---	63.1%	66.6%	68.4%
25 Persistent Beta Blocker Treatment (after AMI; 18+ yrs.)	---	79.0%	77.6%	79.5%
26 Cholesterol Controlled (LDL-C<100 mg/dL; 18-75 yrs.)	---	62.4%	58.2%	56.7%
27 Appropriate Asthma Medications (5-56 yrs.)	88.3%	91.6%	92.1%	92.3%
28 Antidepressant Med. Mgmt. (continuation phase; 18+ yrs.)	---	48.7%	51.3%	50.1%
ACCESS				
29 Follow-up for Mental Illness (w/in 30 days; 6+ yrs.)	83.4%	85.2%	81.0%	82.1%
30 Prenatal Visits (w/in 1 st trimester)	95.6%	96.1%	86.0%	84.4%
31 Postpartum Visits (w/in 21-56 days)	85.6%	85.5%	77.8%	74.7%
32 Well-Child Visits (1 st 15 months; 6+ visits)	82.8%	85.1%	81.9%	84.5%
33 Well-Child Visits (3 rd -6 th years)	83.2%	84.0%	82.8%	83.4%
34 Adolescent Well-Care Visits	57.8%	60.0%	58.7%	59.4%
SATISFACTION				
35 Satisfaction with Healthcare (Q.12; #s8-10)	80.5%	77.2%	76.2%	77.4%
36 Satisfaction with Health Plan (Q.42; #s8-10)	66.3%	65.3%	62.2%	64.5%
37 Ease of Accessing Services (Q.27)	---	89.5%	89.0%	89.7%

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¹ Unless otherwise stated, data are sourced from NCQA's *Quality Compass*, editions 2006-2009

² Source: RI Department of Business Regulation (Jack Broccoli, Chief Insurance Examiner, 401-462-9606); extracted from the NAIC Health Database, data are aggregates (totals) and not averages

APPENDIX E: National Commercial Benchmarks ('best' decile¹)				
	2005	2006	2007	2008
ENROLLMENT				
1 RI Commercial Enrollment (RI member months/12)	---	---	---	---
2 RI Commercial Market Shares	---	---	---	---
COSTS				
3 Premiums (per member per month)	---	---	---	---
4 Medical Expenses (per member per month)	---	---	---	---
5 Administrative Expenses (per member per month)	---	---	---	---
6 Profits (per member per month)	---	---	---	---
UTILIZATION				
7 Hospital Days (per 1,000 members)	---	---	---	---
8 Hospital Discharges (per 1,000 members)	---	---	---	---
9 Average Length of Stay	---	---	---	---
10 ED Visits (per 1,000 members)	138.4 ²	138.9 ²	141.7 ²	141.7 ²
11 Mental Health Services (% accessing care)	---	---	---	---
12 Substance Abuse Services (% accessing care)	---	---	---	---
PREVENTION				
13 Childhood Immunization (combo 2; to 2 yrs.)	86.5%	87.7%	88.1%	88.2%
14 Adult Flu Vaccinations (50-64 yrs., Q.44)	---	55.2%	57.1%	58.1%
15 Smokers Advised to Quit (18+ yrs., Q.46)	78.4%	80.2%	83.0%	82.9%
16 Smoking Cessation Meds Discussed (18+ yrs., Q.47)	48.0%	53.0%	60.2%	63.0%
17 Smoking Cessation Strategy Discussed (18+ yrs., Q.48)	48.2%	52.8%	57.6%	58.2%
SCREENING				
18 Colorectal Cancer Screening (51-80 yrs.)	63.5%	65.1%	65.7%	67.4%
19 Breast Cancer Screening (52-69 yrs.)	80.1%	80.1%	79.1%	76.8%
20 Cervical Cancer Screening (21-64 yrs.)	87.9%	87.1%	86.0%	85.6%
21 Chlamydia Screening (16-24 yrs.)	45.5%	48.6%	48.7%	52.5%
22 Diabetic Eye Exams (18-75 yrs.)	69.3%	71.2%	67.7%	69.8%
23 Diabetic HbA1c Testing (18-75 yrs.)	92.7%	92.9%	92.0%	92.7%
TREATMENT				
24 Hypertension Controlled (<140/90; 18-85 yrs.)	---	68.1%	70.3%	71.6%
25 Persistent Beta Blocker Treatment (after AMI; 18+ yrs.)	---	82.7%	83.1%	84.6%
26 Cholesterol Controlled (LDL-C<100 mg/dL; 18-75 yrs.)	---	66.2%	68.8%	69.0%
27 Appropriate Asthma Medications (5-56 yrs.)	94.1%	94.8%	95.3%	94.9%
28 Antidepressant Med. Mgmt. (continuation phase; 18+ yrs.)	---	53.0%	55.1%	54.4%
ACCESS				
29 Follow-up for Mental Illness (w/in 30 days; 6+ yrs.)	86.4%	87.6%	85.5%	86.0%
30 Prenatal Visits (w/in 1 st trimester)	97.1%	97.5%	97.4%	97.1%
31 Postpartum Visits (w/in 21-56 days)	89.0%	89.1%	89.0%	89.0%
32 Well-Child Visits (1 st 15 months; 6+ visits)	85.9%	88.7%	87.1%	87.4%
33 Well-Child Visits (3 rd -6 th years)	83.2%	83.3%	82.4%	83.2%
34 Adolescent Well-Care Visits	55.0%	57.8%	58.2%	59.6%
SATISFACTION				
35 Satisfaction with Healthcare (Q.12; #s8-10)	83.4%	80.0%	79.4%	80.9%
36 Satisfaction with Health Plan (Q.42; #s8-10)	75.3%	73.2%	71.2%	74.2%
37 Ease of Accessing Services (Q.27)	---	92.5%	92.4%	93.4%

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¹ Benchmarks are the best decile of health plans nationally (i.e., the 90th percentile values, because higher values are preferred), and are sourced from NCQA's *Quality Compass*, editions 2006-2009

² Benchmarks are the best decile of health plans nationally (i.e., the 10th percentile values, because lower values are preferred), and are sourced from NCQA's *Quality Compass*, editions 2006-2009